

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0029595</u></p> <p>Facility Name: <u>THORNTON HEIGHTS TERRACE, LTD.</u></p> <p>Address: <u>106 WEST 10TH STREET</u> <u>CHICAGO HEIGHTS</u> <u>60411</u> Number City Zip Code</p> <p>County: <u>COOK</u></p> <p>Telephone Number: <u>(708) 754-2220</u> Fax # <u>(708) 754-9311</u></p> <p>IDPA ID Number: <u>36-3304964</u></p> <p>Date of Initial License for Current Owners: <u>12/18/95</u></p> <p>Type of Ownership:</p> <table> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steve N. Lavenda</u> Telephone Number: <u>(847) 236-1111</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said content: are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment</p> <table> <tr> <td rowspan="2">Officer or Administrator of Provider</td> <td>(Signed) _____</td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td rowspan="2"></td> <td>(Type or Print Name) _____</td> </tr> <tr> <td>(Title) _____</td> </tr> <tr> <td rowspan="4">Paid Preparer</td> <td>(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u></td> </tr> <tr> <td>(Date) _____</td> </tr> <tr> <td>(Print Name and Title) <u>RICHARD SGARLATA, C.P.A.</u></td> </tr> <tr> <td>(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u></td> </tr> <tr> <td></td> <td>(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u></td> </tr> <tr> <td colspan="2"> MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630 </td> </tr> </table>	Officer or Administrator of Provider	(Signed) _____	(Date) _____		(Type or Print Name) _____	(Title) _____	Paid Preparer	(Signed) <u>SEE ACCOUNTANT'S REPORT ATTACHED</u>	(Date) _____	(Print Name and Title) <u>RICHARD SGARLATA, C.P.A.</u>	(Firm Name & Address) <u>FROST, RUTTENBERG & ROTHBLATT, P.C.</u> <u>111 Pfingsten Rd. , Suite 300, Deerfield, IL 60015</u>		(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
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Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>222</u>	Intermediate (ICF)	<u>222</u>	<u>81,252</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>222</u>	TOTALS	<u>222</u>	<u>81,252</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>75,463</u>	<u>903</u>		<u>76,366</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>75,463</u>	<u>903</u>		<u>76,366</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 93.99%D. How many bed-hold days during this year were paid by Public Aid?
3,477 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/AF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 6/1/84

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 6/1/84 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____Medicare Intermediary N/A

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD. # 0029595 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	A. General Services											
1	Dietary	218,935	30,282	11,900	261,117		261,117		261,117			1
2	Food Purchase		297,698		297,698	(13,615)	284,083	(35)	284,048			2
3	Housekeeping	181,516	41,555		223,071		223,071		223,071			3
4	Laundry	14,533	12,716		27,249		27,249		27,249			4
5	Heat and Other Utilities			120,932	120,932		120,932	1,628	122,560			5
6	Maintenance	86,306		95,133	181,439		181,439	456	181,895			6
7	Other (specify):*											7
8	TOTAL General Services	501,290	382,251	227,965	1,111,506	(13,615)	1,097,891	2,049	1,099,940			8
9	B. Health Care and Programs											
9	Medical Director			2,800	2,800		2,800		2,800			9
10	Nursing and Medical Records	1,049,850	19,028	1,800	1,070,678		1,070,678		1,070,678			10
10a	Therapy	11,143		689	11,832		11,832		11,832			10a
11	Activities	76,640	15,827	3,009	95,476		95,476		95,476			11
12	Social Services	328,123		17,398	345,521		345,521		345,521			12
13	Nurse Aide Training											13
14	Program Transportation			1,985	1,985		1,985		1,985			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,465,756	34,855	27,681	1,528,292		1,528,292		1,528,292			16
17	C. General Administration											
17	Administrative	464,568		705,184	1,169,752		1,169,752	(418,629)	751,123			17
18	Directors Fees			90,000	90,000		90,000		90,000			18
19	Professional Services			20,291	20,291		20,291	654	20,945			19
20	Dues, Fees, Subscriptions & Promotions			27,090	27,090		27,090	(11,655)	15,435			20
21	Clerical & General Office Expenses	234,870	28,934	44,874	308,678		308,678	(24,387)	284,291			21
22	Employee Benefits & Payroll Taxes			434,006	434,006	13,615	447,621	(2,200)	445,421			22
23	Inservice Training & Education											23
24	Travel and Seminar			9,602	9,602		9,602	(6,417)	3,185			24
25	Other Admin. Staff Transportation			1,812	1,812		1,812		1,812			25
26	Insurance-Prop.Liab.Malpractice			67,378	67,378		67,378	103	67,481			26
27	Other (specify):*							7,461	7,461			27
28	TOTAL General Administration	699,438	28,934	1,400,237	2,128,609	13,615	2,142,224	(455,070)	1,687,154			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,666,484	446,040	1,655,883	4,768,407		4,768,407	(453,021)	4,315,386			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

THORNTON HEIGHTS TERRACE, LTD.
0029595
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V
LINE #

22	EMPLOYEE BENEFITS	13,615	
2	FOOD		13,615

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			42,888	42,888		42,888	216,028	258,916			30
31	Amortization of Pre-Op. & Org.							67,352	67,352			31
32	Interest			23	23		23	237,092	237,115			32
33	Real Estate Taxes			411,241	411,241		411,241	5,021	416,262			33
34	Rent-Facility & Grounds			927,772	927,772		927,772	(913,226)	14,546			34
35	Rent-Equipment & Vehicles			26,197	26,197		26,197		26,197			35
36	Other (specify):*											36
37	TOTAL Ownership			1,408,121	1,408,121		1,408,121	(387,733)	1,020,388			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			121,878	121,878		121,878		121,878			42
43	Other (specify):*	41,667			41,667		41,667	(41,667)				43
44	TOTAL Special Cost Centers	41,667		121,878	163,545		163,545	(41,667)	121,878			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,708,151	446,040	3,185,882	6,340,073		6,340,073	(882,421)	5,457,652			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	89,606	30		9
10	Interest and Other Investment Income	(23)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(35)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(6,192)	24		19
20	Contributions	(11,008)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,000)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,117)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax	(21,687)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(65,370)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (22,826)		\$	30

OHF USE ONLY							
48		49		50		51	
						52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(859,595)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (859,595)		36
	(sum of SUBTOTALS)			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (882,421)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
THORNTON HEIGHTS TERRACE, LTD.

Page 5A

ID# 0029595
Report Period Beginning: 01/01/00
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$ 2,247	6 1
2	MISC INCOME	(658)	21 2
3	TRUST FEES	(350)	20 3
4	RESIDENT GIFTS	(2,200)	22 4
5	NON-ALLOWABLE SALARY	(41,667)	43 5
6	Y2001 SEMINAR	(225)	24 6
7	KOPP DUES - ICLTC	(346)	20 7
8	SECTION 754 DEPRECIATION	(18,503)	30 8
9	PAINTING AND DECORATING	(3,666)	6 9
10			10
11			11
12			12
13			13
14			14
15			15
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86			86
87			87
88			88
89			89
90	Total	(65,370)	90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(35)											(35)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities					1,628							1,628	5
6	Maintenance	(1,419)				1,875							456	6
7	Other (specify):*													7
8	TOTAL General Services	(1,454)				3,503							2,049	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative			(101,456)			(317,173)						(418,629)	17
18	Directors Fees													18
19	Professional Services	(1,000)	875		779								654	19
20	Fees, Subscriptions & Promotions	(11,706)			44	7							(11,655)	20
21	Clerical & General Office Expenses	(29,462)	5,988		410	(1,323)							(24,387)	21
22	Employee Benefits & Payroll Taxes	(2,200)											(2,200)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(6,417)											(6,417)	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					103							103	26
27	Other (specify):*			5,114		2,347							7,461	27
28	TOTAL General Administration	(50,785)	6,863	(96,342)	1,233	1,134	(317,173)						(455,070)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(52,239)	6,863	(96,342)	1,233	4,637	(317,173)						(453,021)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00 Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	71,103	144,925										216,028	30
31	Amortization of Pre-Op. & Org.		67,352										67,352	31
32	Interest	(23)	212,315		24,800								237,092	32
33	Real Estate Taxes					5,021							5,021	33
34	Rent-Facility & Grounds		(893,772)			(19,454)							(913,226)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	TOTAL Ownership	71,080	(469,180)		24,800	(14,433)							(387,733)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(41,667)											(41,667)	43
44	TOTAL Special Cost Centers	(41,667)											(41,667)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(22,826)	(462,317)	(96,342)	26,033	(9,796)	(317,173)						(882,421)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENTAL INCOME	\$ 893,772	THORNTON HEIGHTS ASSOCIATES	100.00%	\$	\$ (893,772)	1
2	V	32	INTEREST INCOME	66,836	THORNTON HEIGHTS ASSOCIATES	100.00%		(66,836)	2
3	V	19	ACCOUNTING FEES		THORNTON HEIGHTS ASSOCIATES	100.00%	875	875	3
4	V	32	INTEREST EXPENSE		THORNTON HEIGHTS ASSOCIATES	100.00%	279,151	279,151	4
5	V	30	DEPRECIATION		THORNTON HEIGHTS ASSOCIATES	100.00%	126,422	126,422	5
6	V	31	AMORTIZATION		THORNTON HEIGHTS ASSOCIATES	100.00%	67,352	67,352	6
7	V	21	REPLACEMENT TAX		THORNTON HEIGHTS ASSOCIATES	100.00%	5,988	5,988	7
8	V	30	SECTION 754 DEPRECIATION		THORNTON HEIGHTS ASSOCIATES	100.00%	18,503	18,503	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 960,608			\$ 498,291	\$ * (462,317)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	330,416	REDWOOD MANAGEMENT		\$ (330,416)	15
16	V							16
17	V	17	SALARY-L.SHLOFROCK		REDWOOD MANAGEMENT	228,960	228,960	17
18	V	27	PAYROLL TAXES-LS		REDWOOD MANAGEMENT	5,114	5,114	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 330,416			\$ 234,074	\$ * (96,342)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 PROFESSIONAL FEES	\$	BARTON HEALTHCARE LLC	100.00%	\$ 779	\$ 779	15
16	V	20 DUES, SUBSCRIPTIONS		BARTON HEALTHCARE LLC		44	44	16
17	V	21 CLERICAL		BARTON HEALTHCARE LLC		410	410	17
18	V	32 INTEREST		BARTON HEALTHCARE LLC		278,191	278,191	18
19	V							19
20	V							20
21	V	32 INTEREST	253,391	BARTON HEALTHCARE LLC			(253,391)	21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 253,391			\$ 279,424	\$ * 26,033	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization			
15	V	5 UTILITIES	\$	BARTON MANAGEMENT INC.	100.00%	\$ 1,628	\$	1,628	15
16	V	6 REPAIRS AND MAINT.		BARTON MANAGEMENT INC.		1,875		1,875	16
17	V	20 DUES, SUBS. & FEES		BARTON MANAGEMENT INC.		7		7	17
18	V	21 CLERICAL AND GENERAL		BARTON MANAGEMENT INC.		(1,323)		(1,323)	18
19	V	26 INSURANCE		BARTON MANAGEMENT INC.		103		103	19
20	V	27 EMP. BEN. GEN. ADMIN		BARTON MANAGEMENT INC.		2,347		2,347	20
21	V	33 REAL ESTATE TAXES		BARTON MANAGEMENT INC.		5,021		5,021	21
22	V	34 RENT OFFICE SPACE		BARTON MANAGEMENT INC.		14,546		14,546	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	34 RENT	34,000	BARTON MANAGEMENT INC.				(34,000)	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$ 34,000			\$ 24,204	\$ *	(9,796)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 MANAGEMENT FEES	\$ 374,768	SWS CONS/PAS MANAGEMENT		\$	(374,768)	15
16	V	17 M. SEIGEL COMP		SWS CONS/PAS MANAGEMENT		29,930	29,930	16
17	V	17 M. WEISS COMP		SWS CONS/PAS MANAGEMENT		27,665	27,665	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 374,768			\$ 57,595	\$ * (317,173)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**Report Period Beginning: **01/01/00**Ending: **12/31/00****VII. RELATED PARTIES (continued)**

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD. # 0029595 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	LEON SHLOROCK	SHAREHOLDER	Administrative	21.56%	SEE ATTACHED	9	18.00	Fac/Dir. Fees	\$ 246,960	17-1, 18-3	1
2	JOHN SHLOFROCK	SHAREHOLDER	Administrative	0.33%	SEE ATTACHED	5	10.60	Fac/Dir. Fees	129,853	17-1, 18-3	2
3	ELISA SHLOFROCK-ZUSM	SHAREHOLDER	Clerical	0.33%	SEE ATTACHED	6	15.00	Facility	68,859	21-1	3
4	MARLA COQUILLETTE	SHAREHOLDER	Administrative	9.87%	SEE ATTACHED	15	33.00	Facility	71,897	17-1	4
5	JEAN SHLOFROCK	RELATIVE	Clerical	0.00%	SEE ATTACHED	5	12.50	Facility	15,615	21-1	5
6	RICK DUROS	SHAREHOLDER	Administrative	0.33%	SEE ATTACHED	7	15.55	Facility	46,368	17-1	6
7	GARY WEINTRAUB	SHAREHOLDER	Legal	9.87%	SEE ATTACHED	6	15.00	Facility	39,706	17-1	7
8	MELVIN SEIGEL	SHAREHOLDER	Administrative	0.24%	SEE ATTACHED	8	11.00	Alloc.PAS/Dir	47,930	17-7, 18-3	8
9	MARTIN WEISS	SHAREHOLDER	Administrative	18.06	SEE ATTACHED	6	10.00	Alloc.PAS/Dir	45,665	17-7, 18-3	9
10											10
11											11
12											12
13								TOTAL	\$ 712,853		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number (_____) _____

Fax Number (_____) _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

REDWOOD MANAGEMENT

Street Address

465 CENTRAL AVE., SUITE 100

City / State / Zip Code

NORTHFIELD, IL. 60093

Phone Number

(847) 441-8200

Fax Number

(847) 441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-L.SHLOFROCK	AVG HOURS WORKED	25	5	636,000	636,000	9	228,960	1
2	27	PAYROLL TAXES-LS	AVG HOURS WORKED	25	5	14,206		9	5,114	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 650,206	\$ 636,000		\$ 234,074	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization

BARTON HEALTHCARE, LLC

Street Address

465 CENTRAL AVENUE

City / State / Zip Code

NORTHFIELD, IL 60093

Phone Number

(847) 441-9300

Fax Number

(847) 441-0800

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	29	7	\$ 3,525	\$	7	\$ 779	1
2	20	DUES, SUBSCRIPTIONS	NOTE RECEIVABLE	29	7	200		7	44	2
3	21	CLERICAL	NOTE RECEIVABLE	29	7	1,855		7	410	3
4	32	INTEREST	NOTE RECEIVABLE	29	7	1,258,280		7	278,191	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,263,860	\$		\$ 279,424	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization BARTON MANAGEMENT INC.Street Address 465 CENTRAL AVE.City / State / Zip Code NORTHFIELD, IL 60093Phone Number (847) 441-8200Fax Number (847) 441-0800

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	RENTAL INCOME	199,800	8	\$ 9,569	\$ 34,000	\$ 1,628	1
2	6	REPAIRS AND MAINT.	RENTAL INCOME	199,800	8	11,020	34,000	1,875	2
3	20	DUES, SUBS. & FEES	RENTAL INCOME	199,800	8	40	34,000	7	3
4	21	CLERICAL AND GENERAL	RENTAL INCOME	199,800	8	(7,772)	34,000	(1,323)	4
5	26	INSURANCE	RENTAL INCOME	199,800	8	604	34,000	103	5
6	27	EMP. BEN. GEN. ADMIN	RENTAL INCOME	199,800	8	13,792	34,000	2,347	6
7	33	REAL ESTATE TAXES	RENTAL INCOME	199,800	8	29,507	34,000	5,021	7
8	34	RENT OFFICE SPACE	RENTAL INCOME	199,800	8	85,477	34,000	14,546	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 142,237	\$	\$ 24,204	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization SWS CONS./PAS MANAGEMENT
 Street Address 3500 W PETERSON, SUITE 400
 City / State / Zip Code CHICAGO, IL 60659
 Phone Number (773) 583-3500
 Fax Number (73) 583-3740

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	M. SEIGEL COMP	AVG. HOURS WORKED	74	\$ 276,856	\$ 276,856	8	\$ 29,930	1
2	17	M. WEISS COMP	AVG. HOURS WORKED	60	297,306	297,306	6	27,665	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 574,162	\$ 574,162		\$ 57,595	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number	THORNTON HEIGHTS TERRACE, LTD.
--------------------------------------	---------------------------------------

0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	BARTON HEALTH CARE	X		MORTGAGE	\$27,803.00	1/27/95	\$ 6,500,000	\$ 4,550,024	1/20/15	VARIOUS	\$ 279,151	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$27,803.00		\$ 6,500,000	\$ 4,550,024			\$ 279,151	9	
	B. Non-Facility Related*												
10	Supplemental Schedule										(42,036)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (42,036)	14	
15	TOTALS (line 9+line14)						\$ 6,500,000	\$ 4,550,024			\$ 237,115	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.**

(See instructions.)

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1							\$	\$			\$	1	
2	THORNTON HTS ASSOC	X		INTEREST INCOME							(66,836)	2	
3	ALLOC-BARTON MGMT	X									24,800	3	
4												4	
5												5	
6												6	
7												7	
8												8	
9												9	
10												10	
11												11	
12												12	
13												13	
14												14	
15												15	
16												16	
17												17	
18												18	
19												19	
20												20	
21							\$	\$			(42,036)	21	

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	357,104	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	383,516	2
3. Under or (over) accrual (line 2 minus line 1).	\$	26,412	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	389,850	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	416,262	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	319,927	8
	1996	316,515	9
	1997	326,850	10
	1998	346,703	11
	1999	378,495	12

CALCULATION OF ACCRUAL = 378495 X 1.03 = 389850

ALOLOC. BARTON MANAGEMENT = 5021

FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 1999 \$
14	PLUS APPEAL COST FROM LINE 5 \$
15	LESS REFUND FROM LINE 6 \$
16	AMOUNT TO USE FOR RATE CALCULATION\$

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.

0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,085 B. General Construction Type: Exterior Frame Number of Stories 4

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☐ NO
If so, please complete the following:

1. Total Amount Incurred: 435,383 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 67,352 4. Dates Incurred: 1995-1998

Nature of Costs: THORNTON ASSOCIATION LOAN COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	ALLOC-THORNTON HTS ASSOCIATES			\$ 266,529	1
2					2
3	TOTALS			\$ 266,529	3

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	222		1991		\$ 3,982,306	\$ 126,422	31	\$ 199,115	\$ 72,693	\$ 1,725,663	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1980		5,767		20			5,767	9
10	Various		1981		13,000		20	520	520	11,180	10
11	Various		1985		7,018	357	20	77	(280)	6,448	11
12	Various		1986		13,102	681	20	531	(150)	9,440	12
13	Various		1987		899	29	20	45	16	630	13
14	Various		1989		9,106	289	20	455	166	4,479	14
15	Various		1990		4,093	178	20	178		2,085	15
16	Various		1991		24,882	791	20	918	127	8,614	16
17	Various		1992		10,189	323	20	969	646	7,140	17
18	Various		1993		80,557	2,080	20	4,438	2,358	31,818	18
19	Various		1994		75,510	1,935	20	3,777	1,842	25,203	19
20	Various		1995		56,341	1,479	20	2,816	1,337	16,137	20
21	ELEVATOR CIRCUITS		1996		980	25	20	49	24	221	21
22	DOORS		1996		1,905	49	20	95	46	459	22
23	PANELS		1996		952	24	20	48	24	200	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				75,665	1,353		2,711	1,358	3,546	33
34	PAGE 12B TOTALS				107,308	2,752		5,368	2,616	11,667	34
35	PAGE 12A TOTALS				44,187	1,136		2,211	1,075	8,955	35
36	TOTAL (lines 4 thru 35)				\$ 4,513,767	\$ 139,903		\$ 224,321	\$ 84,418	\$ 1,879,652	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		HEATER/BOILER		1996	1,188	30	20	59	29	261	9
10		WATER METER		1996	2,100	54	20	105	51	499	10
11		DOORS		1996	896	23	20	45	22	206	11
12		PUMP BASEMENT		1996	455	12	20	23	11	104	12
13		DOOR		1996	727	19	20	36	17	162	13
14		WATER METER		1996	3,005	77	20	150	73	713	14
15		WINDOWS		1996	1,076	28	20	54	26	220	15
16		REWIRE ELEVATOR		1996	704	18	20	35	17	158	16
17		DRYER MOTOR		1996	165	4	20	8	4	35	17
18		BATHROOM FLOORS		1996	2,950	76	20	148	72	728	18
19		SHELVING		1996	2,312	59	20	116	57	483	19
20		AIR HANDLER		1996	2,638	68	20	132	64	550	20
21		PANELS		1996	961	25	20	48	23	200	21
22		BASEBOARD COVERS		1996		168	20		(168)		22
23		DOORS		1996	1,374	35	20	69	34	299	23
24		BASEMENT WALLS		1996		141	20		(141)		24
25		EPOXY FLOORS		1996	2,950	76	20	148	72	629	25
26		FAN MOTOR		1997	2,318	59	20	116	57	396	26
27		BATHROOM FLOORS		1997	2,950	76	20	148	72	518	27
28		FLOOD INS REIM		1997		(308)	20		308		28
29		PHONE SYSTEM		1997	4,824	124	20	241	117	904	29
30		CLEAN AIR SYSTEM		1997	3,200	82	20	160	78	627	30
31		TILE		1997	1,600	41	20	80	39	287	31
32		DRAPES		1997	1,329	34	20	66	32	237	32
33		FLOORING		1997	1,790	46	20	90	44	285	33
34		TILE DAYROOM		1997	1,790	46	20	90	44	315	34
35		EPOXY FLOORS		1997	885	23	20	44	21	139	35
36		TOTAL (lines 4 thru 35)			\$ 44,187	\$ 1,136		\$ 2,211	\$ 1,075	\$ 8,955	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FLOORS			1997	1,790	46	20	90	44	300	9
10	FENCE			1997	4,500	115	20	225	110	769	10
11	EPOXY FLOORS			1997	1,180	30	20	59	29	202	11
12	ELECTRIC LINE			1997	1,685	43	20	84	41	336	12
13	TILE BATHROOM			1997	1,790	46	20	90	44	308	13
14	BASEBOARD COVERS			1997	618	16	20	31	15	124	14
15	DRYWALL			1997	1,100	28	20	55	27	220	15
16	BATHROOM FIXTURES			1998	532	14	20	27	13	63	16
17	LIGHT FIXTURES			1998	823	21	20	41	20	85	17
18	AIR CLEANER			1998	1,894	49	20	95	46	245	18
19	RENOVATE ELEVATORS			1998	10,640	273	20	532	259	1,330	19
20	WINDOW			1998	1,885	48	20	94	46	219	20
21	SILVER COAT ROOF			1998	4,700	121	20	235	114	529	21
22	CURTAINS			1998	1,763	45	20	88	43	191	22
23	FLOORING			1998	5,950	153	20	298	145	621	23
24	DOORS			1998	858	22	20	43	21	129	24
25	FLOOR TILE			1998	4,900	126	20	245	119	674	25
26	EPOXY FLOORING			1998	1,975	51	20	99	48	264	26
27	BOILER HEAT BUNDLE			1998	5,225	134	20	261	127	544	27
28	EMERG PANEL			1998	1,650	42	20	83	41	228	28
29	HEATER PUMP			1998	2,887	74	20	144	70	408	29
30	BOILER REPAIRS			1998	959	25	20	48	23	100	30
31	SUMP PUMP			1998	2,550	65	20	128	63	320	31
32	BOILER FIREBOX			1998	3,602	92	20	180	88	465	32
33	ROOFTOP CHILLER			1999	638	16	20	32	16	53	33
34	RENOVATION			1999	40,000	1,026	20	2,000	974	2,833	34
35	CUBICLE CURTAINS			1999	1,214	31	20	61	30	107	35
36	TOTAL (lines 4 thru 35)				\$ 107,308	\$ 2,752		\$ 5,368	\$ 2,616	\$ 11,667	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		LIGHT FIXTURES		1999	735	19	20	37	18	68	9
10		PANELS		1999	1,548	40	20	77	37	141	10
11		TUCKPOINTING		1999	2,235	57	20	112	55	168	11
12		TILE & COVE BASE		1999	1,000	26	20	50	24	83	12
13		TILE FLOORS		1999	5,400	138	20	270	132	338	13
14		DOORS		1999	1,108	28	20	55	27	105	14
15		RAMP HANDRAIL		1999	660	17	20	33	16	36	15
16		SEALCOAT DRIVE & LOT		1999	3,430	88	20	172	84	244	16
17		REPAIR SPRINKLER SYS		1999	1,238	32	20	62	30	78	17
18		FIRE DAMPER		1999	1,880	48	20	94	46	110	18
19		INSTALL TILE		1999	5,550	142	20	278	136	301	19
20		LIGHT FIXTURES		1999	1,123	29	20	56	27	61	20
21		RENOVATE ELEVATOR		1999	14,200	364	20	710	346	1,065	21
22		ROOF EXHAUSTER		1999	600	15	20	30	15	48	22
23		DOOR HOLDERS		1999	1,485	38	20	74	36	99	23
24		FENCE		2000	2,990	61	20	125	64	125	24
25		RENOVATION		2000	11,540	12	20	48	36	48	25
26		AIR CLEANERS (2)		2000	3,800	69	20	143	74	143	26
27		WALL PANELS		2000	4,656	64	20	136	72	136	27
28		WALL PANELS		2000	1,129	13	20	28	15	28	28
29		ELECTRICAL PANELS		2000	1,695	13	20	28	15	28	29
30		GRAVEL		2000	900	5	20	11	6	11	30
31		FLOOR TILE		2000	900	5	20	11	6	11	31
32		DOORS		2000	3,053	10	20	26	16	26	32
33		CUBICLE CURTAINS		2000	736	13	20	28	15	28	33
34		NURSING STATION WALL		2000	2,074	7	20	17	10	17	34
35											35
36		TOTAL (lines 4 thru 35)			\$ 75,665	\$ 1,353		\$ 2,711	\$ 1,358	\$ 3,546	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
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27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
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28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
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14											14	
15											15	
16											16	
17											17	
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27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
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16											16	
17											17	
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28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
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29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
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28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
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28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
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24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34										34
35										35
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
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28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**

Report Period Beginning:

01/01/00

Ending:

12/31/00**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 335,864	\$	\$ 21,706	\$ 21,706		\$ 333,130	37
38	Current Year Purchases	134,295	9,169	11,556	2,387		72,473	38
39	Fully Depreciated Assets	28,462	20,238	1,333	(18,905)		1,333	39
40								40
41	TOTALS	\$ 498,621	\$ 29,407	\$ 34,595	\$ 5,188		\$ 406,936	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 5,278,917	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 169,310	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 258,916	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 89,606	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,286,588	51

**

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	BUILDING	\$ 480,000	\$ 12,308	\$ 50,771	52
53	BUILDING	241,623	6,195	15,746	53
54	LAND	53,349			54
55	LAND	26,847			55
56					56
57	TOTALS	\$ 801,819	\$ 18,503	\$ 66,517	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

THORNTON HEIGHTS TERRACE, LTD.
0029595
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
THORNTON HEIGHTS TERRACE	118,795				118,795
THORNTON HEIGHTS ASSOCIATES	215,634		21,563	21,563	213,833
BARTON MANAGEMENT, INC.	1,435		143	143	502
TOTALS	335,864		21,706	21,706	333,130

LINE 29: CURRENT YEAR

THORNTON HEIGHTS TERRACE	134,295	9,169	11,556	2,387	72,473
THORNTON HEIGHTS ASSOCIATES					
BARTON MANAGEMENT, INC.					
TOTALS	134,295	9,169	11,556	2,387	72,473

LINE 30: FULLY DEPRECIATED

THORNTON HEIGHTS TERRACE	28,462	20,238	1,333	(18,905)	1,333
THORNTON HEIGHTS ASSOCIATES					
BARTON MANAGEMENT, INC.					
TOTALS	28,462	20,238	1,333	(18,905)	1,333

TOTALS (Should Tie to Totals on Page 13)

THORNTON HEIGHTS TERRACE	281,552	29,407	12,889	(16,518)	192,601
THORNTON HEIGHTS ASSOCIATES	215,634		21,563	21,563	213,833
BARTON MANAGEMENT, INC.	1,435		143	143	502
TOTALS	498,621	29,407	34,595	5,188	406,936

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.# 0029595

Report Period Beginning:

01/01/00Ending: 12/31/00**XII. RENTAL COSTS****A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease: NOT APPLICABLE

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	<u>ALLOC-BARTON MGMT</u>				<u>14,546</u>			5
6								6
7	TOTAL				\$ 14,546			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES☐ NO16. Rental Amount for movable equipment: \$ 12,722Description: SEE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY</u>	<u>VAN</u>	\$ <u>550.00</u>	\$ <u>6,600</u>	17
18	<u>FACILITY</u>	<u>VAN</u>	<u>625.00</u>	<u>6,875</u>	18
19					19
20					20
21	TOTAL		\$ #####	\$ 13,475	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.** # **0029595** Report Period Beginning: **01/01/00** Ending: **12/31/00**
XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)									
		1	2	3	4	5	6	7	8
	Service	Schedule V Line & Column Reference	Staff Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)
					Units	Cost			
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$
2	Licensed Speech and Language Development Therapist		hrs						
3	Licensed Recreational Therapist		hrs						
4	Licensed Physical Therapist		hrs						
5	Physician Care		visits						
6	Dental Care		visits						
7	Work Related Program		hrs						
8	Habilitation		hrs						
9	Pharmacy		# of prescrpts						
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs						
11	Academic Education		hrs						
12	Exceptional Care Program								
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**								
14	TOTAL			\$		\$	\$		\$

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 Medical Supplies	
2 Complex Medical Equip	
3 Oxygen	
4 Equipment Rental	
5	
6	
7	
8	
9	
10	
	<u> </u>
	<u> </u>
	<u> </u>
<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 Respiratory Therapy	
2	
3	
4	
5	
6	
7	
8	
9	
10	
	<u> </u>
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	<u> </u>

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 1,078,355	\$ 1,081,621	1
2 Cash-Patient Deposits			2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance)	975,392	975,392	3
4 Supply Inventory (priced at)			4
5 Short-Term Investments		1,345,000	5
6 Prepaid Insurance	41,874	41,874	6
7 Other Prepaid Expenses	3,600	3,600	7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify): See supplemental schedule	600	600	9
TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,099,821	\$ 3,448,087	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land		346,725	13
14 Buildings, at Historical Cost		4,703,929	14
15 Leasehold Improvements, at Historical Cos	512,758	512,758	15
16 Equipment, at Historical Cost	281,550	497,184	16
17 Accumulated Depreciation (book methods)	(338,174)	(1,868,742)	17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs		125,155	19
20 Accumulated Amortization - Organization & Pre-Operating Costs			20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify): See supplemental schedule			23
TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 456,134	\$ 4,317,009	24
TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,555,955	\$ 7,765,096	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 80,580	\$ 92,430	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits			28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	66,645	66,645	30
31 Accrued Taxes Payable (excluding real estate taxes)	18,572	18,572	31
32 Accrued Real Estate Taxes(Sch.IX-B)	389,850	389,850	32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes			35
Other Current Liabilities(specify):			
36 See supplemental schedule	1,212	1,212	36
37			37
TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 556,859	\$ 568,709	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable		4,550,024	39
40 Mortgage Payable			40
41 Bonds Payable			41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43 See supplemental schedule			43
44			44
TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,550,024	45
TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 556,859	\$ 5,118,733	46
47 TOTAL EQUITY (page 18, line 24)	\$ 1,999,096	\$ #REF!	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,555,955	\$ #REF!	48

*(See instructions.)

OTHER CURRENT ASSETS:	Amount	Amount	OTHER CURRENT LIABILITIES:	Amount	Amount
EMPLOYEE ADVANCES	600	600	ACCRUED RETIREMENT PLAN CONTRIBUTION	1,212	1,212
	600	600		1,212	1,212
OTHER NON CURRENT ASSETS:			OTHER NON CURRENT LIABILITIES:		
Construction In Progress					
Utility Deposit					
Loan Costs					

XVI. STATEMENT OF CHANGES IN EQUITY

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,703,764	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,703,764	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	845,332	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(550,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 295,332	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,999,096	24

* This must agree with page 17, line 47.

Facility Name & ID Number	THORNTON HEIGHTS TERRACE, L #	0029595	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	1,703,764
----------------------------	-----------

Adjustments:

-
-
-

Total adjustments

-

Balance - Beginning of Year

1,703,764

Equity(Deficit) from Page 17 Col 1

1,999,096

Related Party

Equity(Deficit)

Income

647267

0

647,267

Combined Equity - End of Year

2,646,363

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.

0029595

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 7,116,982	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,116,982	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic	1,178	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,178	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	64,419	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 64,419	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,826	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,826	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 7,185,405	30

2

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,111,506	31
32	Health Care	1,528,292	32
33	General Administration	2,128,609	33
	B. Capital Expense		
34	Ownership	1,408,121	34
	C. Ancillary Expense		
35	Special Cost Centers	41,667	35
36	Provider Participation Fee	121,878	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,340,073	40
41	Income before Income Taxes (line 30 minus line 40)**	845,332	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 845,332	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? [not complete](#) If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

DESCRIPTION	AMOUNT
1 REFUND ON AUTO LEASE	2,826
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
TOTALS	2,826

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**

0029595

Report Period Beginning:

01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4	
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1 Director of Nursing	2,080	2,200	\$ 58,497	\$ 26.59	1
2 Assistant Director of Nursing					2
3 Registered Nurses	4,563	4,686	95,826	20.45	3
4 Licensed Practical Nurses	20,148	22,428	355,273	15.84	4
5 Nurse Aides & Orderlies	59,565	65,346	524,353	8.02	5
6 Nurse Aide Trainees					6
7 Licensed Therapist					7
8 Rehab/Therapy Aides	521	533	11,143	20.91	8
9 Activity Director					9
10 Activity Assistants	9,091	10,005	76,639	7.66	10
11 Social Service Workers	24,241	26,515	328,123	12.37	11
12 Dietician					12
13 Food Service Supervisor					13
14 Head Cook					14
15 Cook Helpers/Assistants	21,097	23,875	218,935	9.17	15
16 Dishwashers					16
17 Maintenance Workers	8,476	9,437	86,306	9.15	17
18 Housekeepers	21,701	23,790	181,516	7.63	18
19 Laundry	1,994	2,115	14,532	6.87	19
20 Administrator	2,080	2,200	86,118	39.14	20
21 Assistant Administrator	2,886	3,117	54,603	17.52	21
22 Other Administrative	4,791	5,182	323,847	62.49	22
23 Office Manager					23
24 Clerical	12,162	13,011	234,870	18.05	24
25 Vocational Instruction					25
26 Academic Instruction					26
27 Medical Director					27
28 Qualified MR Prof. (QMRP)					28
29 Resident Services Coordinator					29
30 Habilitation Aides (DD Homes)					30
31 Medical Records	1,623	2,032	15,901	7.83	31
32 Other Health Care(specify)					32
33 Other(specify)	625	676	41,667	61.64	33
34 TOTAL (lines 1 - 33)	197,644	217,148	\$ 2,708,149 *	\$ 12.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35 Dietary Consultant	MONTHLY	\$ 11,900	1-3	35
36 Medical Director	121	2,800	9-3	36
37 Medical Records Consultant				37
38 Nurse Consultant				38
39 Pharmacist Consultant	96	1,800	10-3	39
40 Physical Therapy Consultant				40
41 Occupational Therapy Consultant	15	688	10A-3	41
42 Respiratory Therapy Consultant				42
43 Speech Therapy Consultant				43
44 Activity Consultant	86	3,009	11-3	44
45 Social Service Consultant	318	11,118	12-3	45
46 Other(specify)				46
47 PSYCHIATRIC	179	6,280	12-3	47
48				48
49 TOTAL (lines 35 - 48)	815	\$ 37,595		49

C. CONTRACT NURSES

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50 Registered Nurses		\$		50
51 Licensed Practical Nurses				51
52 Nurse Aides				52
53 TOTAL (lines 50 - 52)		\$ 0		53

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
625	676	\$ 41,667	\$ 61.64
625	676	\$ 41,667	\$ 61.64

XIX. SUPPORT SCHEDULES				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
A. Administrative Salaries				Description			Description	
Name	Function	Ownership %	Amount	Amount			Amount	
SEE ATTACHED			\$ 464,568	Workers' Compensation Insurance	\$	58,510	IDPH License Fee	\$
				Unemployment Compensation Insurance		12,617	Advertising: Employee Recruitment	7,231
				FICA Taxes		188,408	Health Care Worker Background Check	252
				Employee Health Insurance		138,410	(Indicate # of checks performed 36)	
				Employee Meals		13,615	DUES-ICLTC	7,118
				Illinois Municipal Retirement Fund (IMRF)*			DUES AND SUBSCRIPTIONS	167
				CHRISTMAS EXPENSE		10,003	LICENSES, FEES AND PERMITS	616
				EMPLOYEE BENEFITS		3,153	ALLOC-BARTON HEALTHCARE	44
				UNION PENSION CONTRIBUTION		19,493	ALLOC-BARTON MGMT	7
				RETIREMENT PLAN CONTRIBUTION		1,212		
							Less: Public Relations Expense	()
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 464,568	TOTAL (agree to Schedule V, line 22, col.8)	\$	445,421	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 15,435
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
REDWOOD MANAGEMENT			\$ 330,416			\$	Out-of-State Travel	\$
SWS MANAGEMENT			374,768					
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 705,184				Seminar Expense	3,184
C. Professional Services							Entertainment Expense	()
Vendor/Payee	Type		Amount				(agree to Sch. V, line 24, col. 8)	
ALPHA DATA	COMPUTER		\$ 3,186	TOTAL		\$	TOTAL	\$ 3,184
CENTRAL PLAZA	COMPUTER		1,856					
ACCU MED	COMPUTER		1,500					
COMPUTER DOCTOR	COMPUTER		448					
ALLOC-BARTON MGMT	COMPUTER		1,815					
FR&R	ACCOUNTING		6,485					
ALLOC-BARTON MGMT	ACCOUNTING		755					
LANER, MUCHIN, DOMBR	LEGAL		3,421					
PERSONNEL PLANNERS	UNEMPLOYMENT CONS		825					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 20,291					

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number **THORNTON HEIGHTS TERRACE, LTD.**# **0029595**Report Period Beginning: **01/01/00**

Ending:

12/31/00**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING AND DECO	1995	\$ 3,003	3	\$ 1,001	\$ 500	\$	\$	\$	\$	\$	\$	\$
2	PAINTING AND DECO	1996	2,950	3	983	983	492						
3	PAINTING AND DECO	1997	4,920	3	820	1,640	1,640	820					
4	PAINTING AND DECO	1998	2,451	3		410	816	816	409				
5	PAINTING AND DECO	2000	3,666	3				611	1,222	1,222	611		
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 16,990		\$ 2,804	\$ 3,533	\$ 2,948	\$ 2,247	\$ 1,631	\$ 1,222	\$ 611	\$	\$

Facility Name & ID Number THORNTON HEIGHTS TERRACE, LTD.

0029595

Report Period Beginning: 01/01/00

Ending: 12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. ICLTC - 7118.00
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YEARS
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ NONE Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 121,878
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? NO
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 13,615 Has any meal income been offset against related costs? NO Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% In 1
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw